

Report of the Outpatient Services Programs Stakeholder Workgroup

Maryland Department of Health and Mental Hygiene

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**Senate Bill 882, Chapter 352 and House Bill 1267, Chapter 353
of the Acts of 2014**

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Message From the Workgroup Chair

Dear Colleagues:

I am pleased to submit the final report of the Outpatient Services Programs Stakeholder Workgroup.

Just one year ago, the Department of Health and Mental Hygiene released the Continuity of Care Advisory Panel's final report. That report included 25 recommendations to improve continuity of care for individuals with serious mental illness. Among other things, the report indicated the need for a well designed outpatient civil commitment program.

Building upon the Continuity of Care Advisory Panel's work, the Outpatient Services Programs Stakeholder Workgroup developed three proposals, which are contained in this report: (1) a proposal to establish an outpatient civil commitment program; (2) a proposal to enhance access to voluntary outpatient mental health services; and (3) a proposal to define dangerousness in regulations and provide comprehensive training around the dangerousness standard. It is anticipated that during the 2015 legislative session legislation will be considered to implement the outpatient civil commitment program contained in this report.

I am grateful for the opportunity to chair this Stakeholder Workgroup. Stakeholders dedicated significant time to develop the proposals contained in this report. The implementation of these proposals will address gaps in the Public Behavioral Health System and improve access to outpatient mental health services.

Gayle Jordan-Randolph, M.D.
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Outpatient Services Programs Stakeholder Workgroup Final Report

Introduction

Senate Bill 882/House Bill 1267 of the 2014 legislative session required the Secretary of Health and Mental Hygiene to convene a stakeholder workgroup to examine the development of assisted outpatient treatment (also known as outpatient civil commitment) programs, assertive community treatment programs, and other outpatient services in the state; develop a proposal for a program in the State; and evaluate the dangerousness standard for involuntary admissions and emergency evaluations.

More specifically, the workgroup was required to develop a proposal that (1) best serves individuals with mental illness who are at high risk for disruptions in continuity of care; (2) respects the civil liberties of individuals to be served; (3) addresses the potential for racial bias and health disparities in program implementation; (4) is based on evidence and effectiveness of outpatient civil commitment programs, assertive community treatment programs, and other outpatient services programs with targeted outreach, engagement, and services in other jurisdictions; (5) includes a data-monitoring strategy; (6) promotes parity between public and private insurers; (7) addresses the potential for variance in program implementation among urban and rural jurisdictions; and (8) assesses the cost of the program to the Department of Health and Mental Hygiene (Department) and other state agencies, including the feasibility of securing federal funding for services provided by the program. The Department was also required to recommend draft legislation as necessary to implement the program included in the proposal.

Additionally, the workgroup was required to evaluate the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders. As part of this evaluation, the workgroup was required to discuss options for clarifying the dangerousness standard in statute or regulations and initiatives to promote the appropriate and consistent application of the standard.

Dr. Gayle Jordan-Randolph, Deputy Secretary for Behavioral Health was appointed by Secretary Sharfstein to chair the Outpatient Services Programs Stakeholder Workgroup, and the Department convened the Outpatient Services Programs Workgroup in May of 2014. Through a series of seven meetings, the workgroup examined both voluntary and involuntary outpatient services, as well as the dangerousness standard. The Department provided opportunities for stakeholder input at each meeting. Further, stakeholders had the opportunity to submit written comments, for the Department's review, after each meeting and provide suggested edits to the draft proposals. Using the stakeholder input, the Department developed this report.

Included in this report are three proposals. These proposals: (1) establish an outpatient civil commitment program, that is outlined in Part I of this document; (2) enhance access to voluntary outpatient mental health services, which is discussed in Part II of this report; and (3) evaluate and clarify the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders, which is included in Part III of this report. It is important to note that legislation would be necessary to implement an outpatient civil commitment program. It is anticipated that legislation to establish an outpatient civil commitment program will be considered during the 2015 legislative session.

The voluntary outpatient services proposal can be implemented with programmatic changes. The dangerousness standard for inpatient admissions can be further clarified through regulations.

The Department consulted with workgroup participants on each element of this report and incorporated many stakeholder comments and suggestions into the final proposals. As expected, however, there were areas where there was no consensus among stakeholders. This is particularly applicable to the outpatient civil commitment proposal. The Department invited participants to submit a written response to the proposals. These responses are included in **Appendix 2** of this report.

I. Proposal 1 - Establish an Outpatient Civil Commitment Program in Maryland

Currently, 45 states have outpatient civil commitment laws. In comparison to inpatient commitment, which confines an individual to a hospital setting, outpatient commitment is court-ordered treatment provided in a community setting. These laws help individuals receive much-needed treatment while remaining in the community. Generally, to qualify for outpatient civil commitment, an individual must have: a mental illness; the capability to survive safely in the community with supports; a need for treatment to prevent further deterioration; and an inability or unwillingness to participate in treatment voluntarily.

In Maryland, however, this option is not available. Court-mandated treatment is currently only permissible in inpatient hospital settings. As a result, many individuals with serious mental illness who refuse to engage in treatment experience homelessness, frequent hospitalizations, increased contact with law enforcement, and incarceration. Both they, and their families, remain in a constant state of crisis. By learning from other states and developing the best possible proposal, we can promote continuity of effective care, as well as help improve the well-being and independence of individuals with severe mental illness.

A. Continuity of Care Advisory Panel

The Department first examined the issue of outpatient civil commitment through the Continuity of Care Advisory Panel, which was formed during the 2013 legislative interim. At the direction of Governor O'Malley, the Department convened the seven-member Continuity of Care Advisory Panel to explore ways to enhance continuity of care for individuals with serious mental illness. The Advisory Panel was charged with examining barriers to continuity of care – economic, social, legal, and clinical – and making recommendations to strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions in care.

To further assist the Advisory Panel with their deliberations, the Department contracted with an independent consultant to provide an analysis of the origin of outpatient civil commitment, a review of outpatient civil commitment research, and options to outpatient civil commitment. The report – *Involuntary Outpatient Commitment: Current Evidence and Options* – found that there is emerging evidence that outpatient civil commitment reduces hospital use and increases engagement in services.¹

¹ Retrieved from: [http://dhmh.maryland.gov/bhd/Documents/Morrissey OPC Final Report %20110413\(1\).pdf](http://dhmh.maryland.gov/bhd/Documents/Morrissey OPC Final Report %20110413(1).pdf)

The Advisory Panel issued a final report in January 2014 that included twenty-five recommendations to strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions in care. A copy of the workgroup's final report may be accessed on the Department's website at: <http://dhmh.maryland.gov/bhd/Documents/Continuity%20of%20Care%20Final%20Report.pdf>. In this report, the Advisory Panel noted that there is a need for a well-designed outpatient civil commitment program in Maryland and recommended that the Department convene a workgroup to further examine the implementation of a program in Maryland and develop an outpatient civil commitment program proposal. After the Advisory Panel issued its report, the Department worked with stakeholders and legislators on the development and passage of Senate Bill 882/House Bill 1267.

B. Stakeholder Process for Comments

Four of the seven workgroup meetings were devoted to the topic of outpatient civil commitment. At each meeting, the applicable provisions of Laura's Law – California's outpatient civil commitment law – were examined and contrasted to outpatient civil commitment laws in select states. The Department provided opportunities for stakeholder input at each meeting. Stakeholders also had the opportunity to submit written comments for the Department's review after each meeting. The workgroup's schedule is outlined below:

- May 25, 2014: The workgroup discussed who should be the target demographic under an outpatient civil commitment program in Maryland and what criteria should be used when determining program eligibility. In order to facilitate conversation in this area the Department provided an overview of Laura's Law and an overview of outpatient civil commitment criteria in select states.
- June 11, 2014: The workgroup focused on determining which outpatient service should be available under an outpatient civil commitment program and estimating the program costs for those services. In addition, this meeting covered the Department's ability to secure federal funding for services and the potential costs to the Department and other state agencies. The Department provided presentations on outpatient services currently available in the public mental health system; opportunities for federal funding; an overview of service provision under Laura's Law; and outpatient civil commitment services in select states.
- July 9, 2014: This meeting included discussion on the data that would need to be collected under an outpatient civil commitment program and developing Departmental reporting requirements. The workgroup also discussed how to avoid racial bias and health disparities and promote parity/access across the State between urban and rural jurisdictions. The workgroup was provided with presentations on reporting requirements under Laura's Law; program evaluation requirements in New York; and the Maryland Program Evaluation Act.
- July 23, 2014: This meeting was dedicated to the rights of the individuals and the potential role of the Judiciary, the Office of Administrative Hearings, and the Office of the Public Defender under an outpatient civil commitment program. The meeting included presentations from each of these agencies as well as a presentation on the rights' of the individual in select states.

Using stakeholder input, the Workgroup developed a proposal for outpatient civil commitment that is modeled after Laura's Law in California. This proposal was circulated to all workgroup participants and other stakeholders for review during the two week comment period. **Appendix 1** includes written comments received from stakeholders and the Department's response, including whether an individual's comments were integrated into the final report.

C. Proposal

Proposal 1 would establish a targeted outpatient civil commitment program in Maryland that provides resources to individuals with severe mental illness who have a history of non-adherence with treatment that has led to repeated inpatient civil commitments. The goal of this program is to improve continuity of care by decreasing interruptions in treatment, stabilizing the individual in the least restrictive environment, and reducing preventable hospitalizations, including inpatient civil commitments. Stakeholders who are supportive of the establishment of outpatient civil commitment indicated that they were generally pleased with the proposal contained in this report and offered comments related to the program's criteria, which are discussed later in this report. Below is a brief overview of this proposal.

1. Petition/Hearing Process

Under this proposal, members of the community can initiate the civil commitment process by submitting a request for investigation to the Department.² All requests must be investigated to determine whether an individual meets the criteria for outpatient civil commitment. Only the Secretary of Health and Mental Hygiene, or his/her designee, can file a petition for outpatient civil commitment with the Office of Administrative Hearings if it is determined that it is likely that all the necessary elements for an outpatient civil commitment petition can be proven by clear and convincing evidence.

Each petition must include: the facts that support the determination that the individual meets each criteria for outpatient civil commitment; a proposed treatment plan; and a certificate signed by a licensed mental health treatment provider certifying that the individual meets the criteria for outpatient civil commitment. If an individual refuses to submit to an examination, he/she can be required to submit to an emergency evaluation. This emergency evaluation process is similar to that used for inpatient admissions. The Office of Administrative Hearings (Office) will hold a hearing on each petition. After considering the evidence presented by the petitioner and the subject of the petition, the Office will grant the petition if the criteria for outpatient civil commitment has been met.

By creating a statewide program that is administered by a single petitioning entity, we can help ensure that services are available in both urban and rural areas and that the program criteria is applied uniformly. This will help avoid health disparities and racial bias in program implementation. Some stakeholders supported this recommendation and noted that a centralized petitioning entity would promote consistency in the program's application; however, others argued that other individuals, particularly

² The following individuals may request the Department to conduct an investigation: (1) any adult who resides with the person who is subject of the petition; (2) any adult, who is the parent, spouse, sibling, or child of the person who is the subject of the petition; (3) the director of a hospital in which the person who is the subject of the petition is, or has been, hospitalized; (4) a licensed mental health treatment provider who is supervising or providing, or has supervised or provided, treatment of the person who is the subject of the petition; (5) a peace officer, parole officer, or probation officer assigned to supervise the person who is the subject of the petition; or (6) a guardian.

family members, should have the ability to petition the Office of Administrative Hearings directly.

2. Criteria

The vast majority of workgroup participants indicated that they were supportive of the outpatient civil commitment criteria outlined in the first reader version of Senate Bill 831/House Bill 767 (2014) - Public Health - Mental Hygiene Law - Assisted Outpatient Treatment. Criteria under Senate Bill 831/House Bill 767 included the following provisions: (1) the individual must be an adult; (2) the individual must have a mental disorder; and (3) the individual must be capable of surviving safely in the community with appropriate outpatient treatment and support; (4) the individual, if not adherent to outpatient treatment, is likely to deteriorate such that he or she will present a danger to the life or safety of the individual or others; (5) the individual must be unlikely to adequately adhere to outpatient treatment on a voluntary basis, as demonstrated by the individual's prior history of nonadherence to voluntary treatment; or specific characteristics of the individual's clinical condition that prevent the individual from making rational and informed decisions regarding mental health treatment; and (6) outpatient civil commitment must be the least restrictive alternative appropriate to maintain the health and safety of the individual.

Despite this consensus, a number of stakeholders supported certain changes to the program criteria, specifically around an individual's capacity to make treatment decisions. Furthermore, there was interest in targeting outpatient civil commitment services to individuals who have frequent contact with the State's psychiatric facilities. While hospitalized and adherent to treatment, these individuals' conditions improve. However, when they return to the community, many refuse to engage in treatment, and their condition deteriorates. Consequently, individuals with serious mental illness who refuse to engage in treatment may experience homelessness, frequent hospitalizations, increased contact with law enforcement, and incarceration.

An outpatient civil commitment program targeting this population would improve continuity of care by decreasing interruptions in treatment, stabilizing the individual in the least restrictive environment, and reducing preventable hospitalizations, including inpatient civil commitments. Therefore, the following criteria is proposed:

- (1) The individual is an adult;
- (2) The individual has a mental disorder as defined by Health- General § 10-101;
- (3) The individual is not providing for or meeting the needs of daily living in the community without supervision, based on a clinical determination;
- (4) At least twice within the past 48 months, the individual has been involuntarily admitted to a facility or Veteran's Administration Hospital under Title 10, Subtitle 6, Part III of the Health-General Article;
- (5) The individual has been offered an opportunity to participate voluntarily in recommended treatment but either declines to do so or fails to adhere to treatment recommendations;
- (6) In view of the individual's treatment history and current behavior, the individual is in need of mandatory outpatient treatment in order to prevent deterioration that would be likely to result in the individual meeting the criteria for involuntary admission under Health-General § 10-617;
- (7) The individual is likely to benefit from outpatient treatment that will help protect the individual

- from interruptions in treatment, relapses, or deterioration of mental health; and
- (8) There is no appropriate and less restrictive alternative.

3. Mandated Services

The majority of stakeholders noted that intensive case management or Assertive Community Treatment should be a mandated service under an outpatient civil commitment program. Nontraditional outpatient services, such as mobile treatment were also recommended. Therefore, this proposal includes either case management or Assertive Community Treatment Services as mandated services to ensure care coordination. Optional services include: medication; periodic blood tests or urinalysis to determine compliance with prescribed medications; individual or group therapy; day or partial day programming activities; education and vocational training or activities; alcohol or substance use disorder treatment, counseling, and periodic tests for the presence of alcohol, illegal drugs, or prescription drugs, if an individual has a history of substance use disorder; supervision of living arrangements; and peer support. This is not an exhaustive list; other services necessary to treat the individual's mental illness and assist the individual in living and functioning in the community should be provided under this program, including services aimed at preventing a relapse or further deterioration that may result in suicide or the need for hospitalization.

4. Civil Liberties

The Workgroup recognizes that any outpatient civil commitment program must include clear civil liberty protections to ensure that individuals' rights are safeguarded throughout each stage of the process. Therefore, this proposal includes language explicitly detailing the rights of individuals that are subject to a petition for outpatient civil commitment. These rights include: the right to retain counsel, or if the individual qualifies, use the services of a court-appointed public defender; the right to receive notice of the Department's petition and notice of the hearing; the right to receive a copy of the results of the investigation of the Secretary; the right to present evidence, call witnesses, and cross-examine adverse witnesses at the outpatient civil commitment hearing; the right to be informed of the right to judicial review of the Office's decision; the right not to be involuntarily committed solely for failure to comply with an order; the right to be present at a hearing, unless the individual waives that right; the right to receive treatment in the least restrictive setting deemed appropriate and feasible; and to the extent possible, the right to have any conditions and treatments stated in the subject of a petitions advanced directive for mental health treatment to be honored and included in the treatment plan.

Further, the proposal also lists those actions that would not be considered a refusal to comply with a treatment order. Those actions include: a willingness to take medication as required under an order, but a reasonable disagreement about the type or dosage of the medication; an inability to obtain access to appropriate treatment because of inadequate health care coverage or an insurer's refusal or delay in providing coverage for the treatment; or the inability of an individual who is in the custody of the Department of Public Safety and Correctional Services or a local detention center to participate in treatment.

5. Data Collection and Reporting

Stakeholder feedback on data and reporting requirements under an outpatient civil commitment program was diverse. Reporting requirements under Kendra's Law – New York's outpatient civil commitment law – and requirements included in the 2005 reauthorization of the law were cited by several stakeholders as an appropriate starting point when developing reporting requirements in Maryland. Additional data identified by stakeholders included information on the number of petition requests filed by non-providers; an individual's living situation pre and post program participation; quality of life assessments; demographic information such as race; and treatment outcomes, including medication outcomes. Stakeholders also noted that having a program evaluation conducted by an entity other than the Department would be beneficial.

Based on these comments, this proposal requires the Department to submit an annual report to the General Assembly summarizing the number of orders issued during a 12-month period. For individuals that were the subject of an order, the Department should report on the number of individuals who: (1) maintained contact with the treatment system; (2) maintained housing; (3) participated in employment services; (4) were hospitalized; and (5) came in contact with local law enforcement. Demographic information – including race, gender, income, education and disability – by jurisdiction should also be reported. Costs to administer the program within the Department, as well as costs to other agencies should also be reported. Additional reporting requirements should also include adherence to treatment plans; treatment outcomes, including medication outcomes; substance abuse by individuals who are the subject of an order; type, intensity, and frequency of treatment that are included in treatment plans included in orders; satisfaction with outpatient civil commitment by individuals receiving services and by their families when relevant; and the extent to which enforcement mechanisms are used and the outcome of the enforcement mechanism. In addition to annual reporting, this proposal requires that the program undergo a Sunset Evaluation in accordance with the Maryland Program Evaluation Act. Such an evaluation should also examine the impact of capitated programs, such as Assertive Community Treatment, they were originally designed.

6. Proposed Costs

It is estimated that an additional \$3.0 million per 100 individuals would be needed to administer an outpatient civil commitment program, and provide needed community-based services. This includes \$2.5 million, or approximately \$25,000 per individual committed, for services. These estimates were developed based on costs in other states, namely New York and California. To the extent that an individual is Medicaid-eligible, the State would receive federal financial participation for services offered under the program.

This estimate also includes approximately \$0.5 million for increased staffing to manage an outpatient civil commitment program. The following positions would be necessary for every 100 individuals committed to services: 2 Social Workers, 1 Management Associate, 0.5 Assistant Attorney General, and 0.5 Staff Attorneys. The Department estimates that this would cost approximately \$0.4 million for salaries and fringe benefits for this staffing complement. Attorney representation and consultation is necessary due to the administrative process associated with the program, social workers would be needed to monitor the program and assist in program development, and a management associate

is needed to provide administrative support. Staffing estimates also include \$0.1 million to conduct evaluations and for expert testimony at administrative hearings.

This proposal would also have to reimburse the Office of Administrative Hearings based on the proportion of their time spent on outpatient civil commitment cases. If the Office of Administrative Hearings spent 1 hour on each case, and there were 100 cases, the Department's Office of Administrative Hearings-related charges would increase by approximately \$20,000³. According to its Managing for Results measures, the Office of the Public Defender has 8.5 attorney's in its mental health division. These public defenders have a caseload of roughly 850 cases annually. To the extent that caseloads increase, the Office of the Public Defender's expenditures may increase.

7. Federal Funding Opportunities

It is important to note that newly authorized federal funding may also be available to support an outpatient civil commitment program. H.R.4302 was signed into law on April 1, 2014. While the majority of the law relates to Medicare payments to physicians, it also authorizes a total of \$60 million over four years to fund the expansion of outpatient civil commitment. Congress authorized \$15 million annually for fiscal years 2015 through 2018. Through a four-year pilot program, the federal government must award no more than 50 grants each year to eligible entities for outpatient civil commitment programs for individuals with serious mental illness.

Eligible entities who may apply for grants include counties, cities, mental health systems, mental health courts, or any other entities with authority under the law of the State in which the grantee is located to implement, monitor, and oversee outpatient civil commitment program. In order to apply for funding, applicants must not have previously implemented an outpatient civil commitment program, and must agree to evaluate and report on treatment outcomes and other criteria. When awarding grants, the federal government must evaluate applicants based on their potential to reduce hospitalization, homelessness, incarceration, and interaction with the criminal justice system while improving the health and social outcomes of the patients.

Programs that receive funding under H.R. 4302 must: (1) evaluate the medical and social needs of patients that are participating in the program; (2) prepare and execute treatment plans that include criteria for completion of court-ordered treatment and provide for monitoring of the patient's compliance with the treatment plan, including compliance with medication and other treatment regimens; (3) provide case management services that support the treatment plan; (4) ensure appropriate referrals to medical and social service providers; (5) evaluate the process for implementing the program to ensure consistency with the patient's needs and the state law; and (6) measure treatment outcomes, including health and social outcomes such as rates of incarceration, health care utilization, and homelessness.

³ Based on current expenditures, the Department is charged \$194.44 per hour by the Office of Administrative Hearings. One hour per case was used as an estimate as current involuntary admission cases are charged at half an hour per case. Since this would be a new type of hearing, additional time was allotted.

II. Proposal 2 - Enhance Access to Voluntary Outpatient Mental Health Services

Based on stakeholder input, proposal 2 was developed to enhance access to voluntary outpatient mental health services to improve access to: (1) Assertive Community Treatment teams; (2) peer support; (3) housing for the seriously mentally ill; and (4) crisis services. It should be noted that additional funding would be necessary to make these types of enhancements to the Public Behavioral Health System. The need for additional funding is supported by stakeholders. More specifically, stakeholders indicated funding should not be diverted from existing services to fund these initiatives.

Two of the seven workgroup meetings were devoted to the topic of voluntary outpatient services. Opportunities were provided for stakeholder input at both meetings, and there was a written comment period after each meeting. The workgroup's meetings devoted to voluntary outpatient mental health services are summarized below:

- May 20, 2014: At this introductory meeting, the Department reviewed the workgroup's mandate under its establishing legislation and summarized the process for stakeholder comment and participation. The Department provided stakeholders with an overview of outpatient services funded under Maryland's public mental health system. Dr. Anita Everett - Johns Hopkins Bayview, Division Director of Community and General Psychiatry provided the workgroup with an overview of Assertive Community Treatment, including variations of the program and capitated programs.
- June 24, 2014: The workgroup examined access to voluntary outpatient mental health services and discussed how existing services may be enhanced. The Department provided a presentation on crisis services in Maryland. A guest from On Our Own, Maryland – Denise Camp, Outreach Trainer/Coordinator – provided the group with a presentation on the importance of peer support. Finally, Lisa Kornberg, Executive Director of the Governor's Office of the Deaf and Hard of Hearing presented on working with individuals who are deaf or hard of hearing.

Stakeholder Input

This proposal incorporated stakeholder comments. The draft proposal was circulated to all workgroup participants and other stakeholders. There was a two week comment period and **Appendix 3** includes comments received, and the Department's response to comments, including whether comments were accepted and integrated in this final report.

Assertive Community Treatment

The Department currently provides Assertive Community Treatment services throughout Maryland, but on a limited basis. Assertive Community Treatment provides intensive, mobile, assertive mental health treatment and support services to individuals. Services are delivered by a multidisciplinary treatment team to adults whose mental health needs have not been met through traditional outpatient mental health programs. Treatment teams include psychiatrists, nurses, mental health professionals, employment specialists, and substance use specialists. Services may be delivered in an individual's home, where they work, or other community settings where assessment, intervention and support is needed.

Currently, Assertive Community Treatment teams serve individuals through 19 teams in Anne Arundel, Baltimore (two teams), Carroll, Frederick, Harford, Howard, Montgomery (two teams), Prince George's, and Washington counties as well as Baltimore City (six teams), and the Lower-shore and Mid-shore areas. Services are available 24 hours a day, 7 days a week.

Through the Outpatient Services Program's Workgroup, stakeholders also discussed the potential impact of an outpatient civil commitment program on access to voluntary mental health services in Maryland. The impact of outpatient civil commitment on New York's public mental health system was highlighted in New York State Assisted Outpatient Treatment Program Evaluation. Among other things, it was unclear whether resources were diverted away from other adults with severe mental illness as a result of outpatient civil commitment implementation. In New York, the implementation of outpatient civil commitment was supplemented by large increases in funding, which over time increased the availability of intensive services for all outpatient individuals, even those who did not receive outpatient civil commitment treatment. In the first few years when outpatient civil commitment was implemented, evaluators found that preference for intensive case management was given to outpatient civil commitment cases. This meant that individuals who were not under an outpatient civil commitment order were less likely to receive case management services than those under an outpatient civil commitment order. This especially held true outside of New York City.⁴

The expansion of Assertive Community Treatment is needed regardless of whether an outpatient civil commitment program is implemented in Maryland. However, if a program were established, the Department must consider the effects of an outpatient civil commitment program on access to voluntary outpatient mental health services. Based on findings in New York, it is recommended that if an outpatient civil commitment program is implemented in Maryland – that includes Assertive Community Treatment services – that the Department must increase funding to expand Assertive Community Treatment for individuals seeking services voluntarily.

In order to create an additional Assertive Community Treatment Team, \$0.6 million would be required. This includes start up costs for the first year for one 50 consumer team (\$0.5 million), and for training and technical assistance infrastructure (\$0.1 million). When expanding Assertive Community Treatment, the Department should consider jurisdictional need and the demand for treatment teams as a result of outpatient civil commitment. The current eligibility for capitation programs should be examined to determine whether eligibility should be expanded to address high utilizers. Similarly, the Department should investigate and consider changes to regulations that currently preclude Federally Qualified Health Centers from participating in Assertive Community Treatment Teams and receiving reimbursement that recognizes the more intense service provision.

Peer Support Services

Peer support specialists are consumers with lived experience with behavioral health who are in recovery. Presently, peer support has been integrated into Assertive Community Treatment teams; however several stakeholders noted that that peer support should be further integrated into other outpatient mental health services. Moreover, the Continuity of Care Advisory Panel recommended that the use of peer support specialists in the public mental health system should be further studied by the

⁴ Retrieved from: http://www.macarthur.virginia.edu/aot_finalreport.pdf

Department. Based on stakeholder input it is recommended that additional funding be appropriated to expand peer support services within each jurisdiction. Expansion should include the public mental health service delivery system, local detention centers, courts and primary care.

In order to fund one full time peer support specialist at each Core Service Agency, the Department estimates that this would cost approximately \$0.6 million annually. This assumes a peer support specialist receives an annual salary of roughly \$31,000.

Housing

Written comments submitted by stakeholders consistently identified housing as an area that needed enhancement in the public mental health system. Multiple stakeholders noted that housing is a key component to ensuring an individual is stable and can remain stable in the future. Similar input was solicited through the Continuity of Care Advisory Panel. Among other things, the Panel noted that care can be interrupted when there is inadequate access to needed behavioral health services. The Panel's workgroup's cited a number of areas where there is need for the expansion of specific services, including residential housing for the seriously mentally ill. It was recommended by the Advisory Panel, that within the context of behavioral health integration, the Department continue to monitor and evaluate its ability to enhance and expand services in this area.

Appendix 4 outlines housing programs administered by each Core Service Agency in the state. As the chart shows, there is variation in the number of individuals served by Core Service Agency as well as variation in the types of housing resources offered. Based on stakeholder input, and the Department's survey of Core Service Agencies, it is recommended that the Department increase funding for rental subsidies. The median cost associated with BHA's rental subsidies is \$9,946. This ranges from a low of \$6,720 per year per person to a high of \$13,171 per year per person. Using the median point of \$9,946, an additional 50 individuals would be able to receive rental subsidies for every \$500,000 appropriated in accordance with this proposal.

Crisis Services

Crisis services serve as an alternative to traditional programs and can be viewed as a continuum of services. This continuum may include a 24/7 hotline, walk-in crisis services, mobile crisis teams, police-based Crisis Intervention Teams, urgent care clinics, emergency department psychiatric services, 23 hour holding beds, crisis residential beds, case management, and court-based diversion.

All jurisdictions offer crisis services; however services vary by jurisdictional need and funding sources. Through a supplemental budget bill in fiscal 2014, \$3.5 million was appropriated to expand crisis services in the State. Of this amount, \$2.0 million was provided to enhance or add to crisis services and \$1.5 million was allocated to fund Crisis Intervention Team programs. **Appendix 5** outlines current crisis services administered by each Core Service Agency; enhancements that are being made through supplemental funding; and the implementation status of each enhancement. As shown in Appendix 5, while numerous enhancements are occurring in each jurisdiction, gaps remain in the crisis services continuum. Moreover, crisis services are not readily accessible to individuals who are deaf and hard of hearing due to a lack of training and staff fluent in ASL. It is recommended that additional funding be appropriated to further integrate and enhance crisis services, within each jurisdiction. Enhancing crisis

services for the deaf and hard of hearing should also be prioritized. If additional funding were appropriated, the Department would distribute funding to Core Service Agencies using inpatient bed utilization as a proxy for demand for crisis services, or allocate funding evenly amongst jurisdictions to increase core levels of funding for crisis services.

III. Proposal 3 - Define Dangerousness in Regulations and Provide Comprehensive Training Around the Dangerousness Standard

Senate Bill 882/House Bill 1267 of 2014 also required the Outpatient Services Programs Stakeholder Workgroup to evaluate the dangerousness standard for involuntary admissions and emergency evaluations of individuals with mental disorders, including: how the standard should be clarified in statute or in regulations adopted by the Department; and initiatives the Department should adopt and implement to promote the appropriate and consistent application of the standard by healthcare professionals, administrative law judges, the Office of the Public Defender, consumers, and other individuals. The Workgroup held one meeting to discuss this topic.

Background

This proposal draws upon observations and recommendations made by the Continuity of Care Advisory Panel. Following its review of the dangerousness standard, the Panel found that in practice, there was variance in how the dangerousness standard is interpreted across the healthcare system. This has led to inconsistent application of the dangerousness standard in various settings, including emergency evaluations.

Ultimately, the Panel recommended that the Department promulgate regulations defining dangerousness to promote consistent application of the standard throughout the healthcare system; and to further ensure consistency, the Department should develop and implement a training program for healthcare professionals regarding the dangerousness standard as it relates to conducting emergency evaluations and treatment of individuals in crisis. It was recommended that training should be extended beyond the emergency room to Administrative Law Judges, the Office of the Public Defender, consumers and family members to ensure consistent application of the standard statewide.

It is important to note that the Panel concluded that a gravely disabled standard was not needed to address inconsistencies in involuntary admission practices. Rather, the Panel found that dangerousness to self is included in the civil commitment criteria; variances in involuntary admissions are the result of other factors, including the application and interpretation of “dangerousness to self,” failure of the State to define “dangerousness,” and inadequate training of providers, first responders, and administrative and legal professionals on how to apply the dangerousness standard.

Current Law

Under current law, the dangerousness standard is only one of six criteria used when determining whether an individual may be admitted to a facility involuntarily. A health care facility or Veterans’ Administration hospital may not involuntarily admit an individual unless (1) the individual presents a danger to the life or safety of the individual or of others; (2) the individual has a mental disorder (3) the individual needs inpatient care or treatment; (4) the individual is unable or unwilling to be admitted

voluntarily; (5) there is no available, less restrictive form of intervention that is consistent with the welfare and the safety of the individual; and (6) if the individual is 65 years old or older and is to be admitted to a State facility, the individual has been evaluated by a geriatric evaluation team, and no less restrictive form of care or treatment was determined by the team to be appropriate. As a matter of federal constitutional law, an individual may not be confined to a hospital involuntarily unless the State proves by clear and convincing evidence, that the individual is a danger to the life or safety of the individual or others.⁵

Proposed Definition of Dangerousness

Consistent with the Continuity of Care Advisory Panel's recommendation, the Department proposes the following definition of dangerousness to promulgate in regulations:

"Danger to the life or safety of the individual or of others" means, in consideration of the individual's current condition and, if available, personal and medical history, that:

- (1) There is a substantial risk that the individual will cause harm to the person or others if admission is not ordered; or
- (2) The individual so lacks the ability to care for himself or herself that there is a substantial risk of death or serious bodily injury if admission is not ordered."

Stakeholder Comments: Psychiatric Deterioration

This proposed definition was circulated to all workgroup participants and other stakeholders. There was a two week comment period. The majority of stakeholder comments supported the inclusion of psychiatric deterioration in the definition of "danger to the life or safety of the individual or others." These comments were considered, but the Department made the decision not to include psychiatric deterioration in the definition due to concerns that involuntary hospitalization may not always be the clinically appropriate level of care for all individuals at risk for psychiatric deterioration. For those individuals whose psychiatric deterioration that has not resulted in them presenting a current danger to themselves or others, inpatient hospitalization often is not clinically appropriate. To further illustrate this concerns, the Department offers the three scenarios below.

Scenario 1: Mr. A is a 28 year old man who was emergency petitioned to the emergency department due to threatening behavior directed toward his family. He reports hearing voices telling him that his family is poisoning his food. He expressed frustration, thoughts of suicide and aggression toward those he views as his persecutors. He has a history of 3 prior psychiatric admissions over the previous 7 years, all in the context of psychotic, paranoid symptoms. Each hospitalization was brief, the longest lasting 12 days, during which he responded quickly to antipsychotic medications and psychosocial support. He reports that he stopped attending treatment at his outpatient program "a while ago" because "I was better and didn't need it

⁵ In *O'Connor v. Donaldson*, 422 U.S. 563 (1975), the United States Supreme Court ruled that "a State cannot constitutionally confine, without more, a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." In *Addington v. Texas*, 441 U.S. 418 (1979), the Court determined that the appropriate standard of proof of dangerousness is clear and convincing evidence. Neither case has been limited or overruled.

anymore.” In the emergency department, his physical exam, lab values and tox screen are normal. He is in the quiet room, yet takes an aggressive stance on approach. He denies any intention to harm anyone specifically, saying “I just want to be left alone.” Mr. A’s active psychotic symptoms coupled with his poor frustration tolerance and aggressive posturing (impaired judgment) support the need of inpatient psychiatric treatment for crisis stabilization.

Scenario 2: Mr. B is a 28 year old man who was taken to the emergency department by family due to increasing frequency of panic attacks. He has a long history of panic disorder, dating back about 7 years. He works from home as a web designer. He has been followed as an outpatient by a psychiatrist and a therapist and has never been hospitalized. His panic symptoms were well managed until he stopped attending treatment “a while ago” because “I was better and didn’t need it anymore.” In the emergency department, he reports that from time to time he has been so paralyzed by his panic symptoms that he fears leaving his home. He orders food from a local supermarket which delivers his groceries to his home. His physical exam, lab values (including thyroid function tests and tox screen) and EKG are normal, suggesting that he has maintained adequate nutrition.

Scenario 3: Ms. C is a 28 year old woman brought to the emergency department by police after threatening a police officer who suggested that she should go into a code blue shelter. The police officer found her sleeping under a bridge in the middle of a snow storm. In the hospital, records indicate that she had been involuntarily committed six months previously. Her physical exam suggests that she is malnourished and is suffering from frostbite on her fingers. She acknowledged that she has not kept her appointments or followed up with her medication, and says that “the voices are getting louder.” She vociferously declined the offer of a voluntary admission, yelling “you just want to lock me up and throw away the key” and then trying to run out of the emergency department.

Using the proposed definition of “danger to the life or safety of the individual or of others,” the individual described in Scenario 1 and 3 could be admitted involuntarily, while the individual described in Scenario 2 would not:

- In scenario 1, the emergency department clinicians would likely diagnose Mr. A with a psychotic disorder. Attempts to treat his psychosis in the emergency department may be insufficient given his chronic history. If he continues to present with aggressive or threatening behaviors while in the quiet room, he could be certified in the emergency department for inpatient admission.
- However, in scenario 2, Mr. B almost certainly would not require admission, however serious his illness might appear initially. Emergency room treatment to address Mr. B’s symptoms would most likely include the initiation of both pharmacological and psychotherapeutic treatment targeting his anxiety disorder. Depending on the location, these clinicians may have access to urgent care or walk in clinics. Even if they do not, it is reasonably likely that this individual could be referred back to his treating psychiatrist, who would reengage him in treatment. Even if this man were believed to be “gravely disabled” or “likely to deteriorate,” very few clinicians would view this individual as someone who should be subjected to involuntary inpatient treatment as he does not pose a danger to the life or safety of himself or others.

- Finally, in scenario 3, Ms. C clearly is a person who requires inpatient care at the present time, involuntarily if needed.

If the proposed definition was altered to include psychiatric deterioration, all three individuals would be involuntarily admitted. This would not be clinically appropriate for Mr. B because he does not present as dangerous; thus he does not meet the standard for involuntary admission.

Much of the feedback received focused on the perceived need to include language within the dangerousness criteria regarding the risk of psychiatric deterioration. The Department does not believe that this is either necessary or wise. The dangerousness criteria, as revised, characterizes individuals suffering with mental illness who *in the present moment* pose a public safety risk, broadly defined to include substantial risk to themselves either affirmatively or passively. Thus, the language codifies what the Department believes to be the proper practice: liberty is to be infringed only when there is a current risk. It captures the concept, if not the language, of grave disability. Adding language to include risk of deterioration would create a vastly overbroad group of people who could be subjected to involuntary commitment, as most everyone could be considered at such risk at some point in time, regardless of their willingness to engage in treatment.

Stakeholder Comments: Statutory vs. Regulatory Change

Some stakeholders also noted that dangerousness should be defined in statute as opposed to regulation. Proceeding through regulations, as opposed to legislation, is recommended because if concerns are identified in the implementation of this definition of “dangerousness,” then the regulations can be amended without requiring the passage of new legislation. Additionally, the regulatory review process would provide the Department with an opportunity to get further input from providers, consumers, and other interested stakeholders and incorporate that input into the amended regulations. The Department plans on posting the regulations for formal comment in early 2015.

Other Stakeholder Comments

A minority of stakeholders indicated that “danger to the life or safety of the individual or of others” did not need to be further defined. More specifically, stakeholders argued that the Department should implement training around the current standard to address its inconsistent application. The standard could then be further defined if training did not promote consistent application of the standard. The Department considered these comments; however Senate Bill 882/House Bill 1267 of 2014 requires the Workgroup to determine how the standard should be clarified in regulations and statute and the Department supports further clarification of the current standard.

Other stakeholders noted that terms that are used in the proposed definition, including “substantial risk” and “will cause harm,” will make it more difficult to involuntarily admit an individual and suggested the use of a lower legal standard. After considering these comments the Department believes that the inclusion of these terms is necessary to sufficiently protect individuals’ civil liberties. The use of a lower legal standard would not adequately address these concerns. Training modules created by the Department will be designed to ensure that these terms are adequately explained to ensure consistent and clinically appropriate application of the standard.

Training

The Outpatient Services Programs Stakeholder Workgroup was also required to develop initiatives to promote the appropriate and consistent application of the dangerousness standard. Once a new standard is adopted, training methodologies will include case-based training to illustrate questionable scenarios. Pre and post test training tests will be used to determine whether individuals met learning objectives.

Training modules will also be designed for specific audiences. The Department advises that the following audiences would benefit from training around the dangerousness standard:

- first responders,
- emergency department clinicians,
- inpatient psychiatric staff,
- including hospital presenters,
- Administrative Law Judges, and
- public defenders.

Implementation of these new training modules will require assistance from stakeholders including: EMS and law enforcement agencies, the Maryland Hospital Association, the Office of Administrative Hearings, the Office of the Public Defender, the statewide academic health centers, and professional organizations, such as the Maryland Psychiatric Society.

Training will be developed to target the needs of specific audiences. For example, the needs of clinicians working in emergency or crisis settings are quite different from the needs of Administrative Law Judges tasked with making decisions using civil commitment law - which includes a finding as to dangerousness. Thus, first responders and emergency clinicians must make rapid decisions based on limited information, so their training will focus on how best to make good decisions in the context of their work. By contrast, inpatient mental health staff have time to gather information, talk with the patient and his/her significant others, and gather prior records, and can make a more considered decision regarding the need for continued acute involuntary treatment. Administrative Law Judges and defense counsel are in a place to more strictly consider the legal standard as applied to the facts presented in evidence, and their role is to ensure that there is a proper balance between the patient's rights and public safety considerations. Through partnerships with the various stakeholders, trainings will be designed to meet each group's specific needs and ensure a full but targeted understanding of the standard as it is to be considered and/or applied by that group.

To ensure that the training modules have the widest possible distribution, they will be adapted as webinars suitable for distance learning. Webinars will be recorded to allow for later viewing by participants unable to join live training exercises. This will be especially important for workers on off-shifts, as is commonly the case for first responders and emergency clinicians.

The content of the training will include, as relevant to the specific audience, education regarding the dangerousness standard as it is to be applied during the “emergency petition” phase of a particular case and during the various civil commitment procedures and proceedings. In addition, examples will be incorporated into the trainings to allow participants to examine specific issues likely to arise during their work with people with mental illness. These examples will vary based on the audience targeted and based on the phase of the process being discussed.